

STATE OF CONNECTICUT



***AUDITORS' REPORT
UNIVERSITY OF CONNECTICUT HEALTH CENTER
FOR THE FISCAL YEARS ENDED JUNE 30, 2005 AND 2006***

AUDITORS OF PUBLIC ACCOUNTS

KEVIN P. JOHNSTON ❖ ROBERT G. JAEKLE

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July 30, 2008

**AUDITORS' REPORT
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FOR THE FISCAL YEARS ENDED JUNE 30, 2005 AND 2006**

We examined the financial records of the University of Connecticut Health Center (Health Center) for the fiscal years ended June 30, 2005 and 2006. The Health Center is a component unit of the University of Connecticut system, which includes the University of Connecticut (University), the Health Center, the University of Connecticut Foundation, Inc. (Foundation) and the University of Connecticut Law School Foundation, Inc. This report on that examination consists of the Comments, Recommendations and Certification that follow.

Financial statement presentation and auditing are done on a Statewide Single Audit basis to include all State agencies. This audit has been limited to assessing the Health Center's compliance with certain provisions of financial related laws, regulations and contracts, and evaluating the Health Center's internal control structure policies and procedures established to ensure such compliance.

COMMENTS

FOREWORD:

The Health Center operates generally under the provisions of Title 10a, Chapter 185, where applicable, Chapter 185b, Part III, and Chapter 187c of the General Statutes. Together, the University and the Health Center are a constituent unit of the State system of public higher education under the central authority of the Board of Governors of Higher Education. The Health Center is governed by a Board of Trustees of the University of Connecticut, consisting of 21 members appointed or elected under the provisions of Section 10a-103 of the General Statutes.

Auditors of Public Accounts

This Board, subject to Statewide policy and guidelines established by the Board of Governors of Higher Education, makes rules for the government of the Health Center and sets policies for administration of the Health Center pursuant to duties set forth in Section 10a-104 of the General Statutes. The members of the Board of Trustees as of June 30, 2006, were:

Ex officio members:

M. Jodi Rell, Governor
James F. Abromaitis, Commissioner of Economic and Community Development
Gerard N. Burrow, M.D., Chairperson of the Health Center's Board of Directors
F. Philip Prelli, Commissioner of Agriculture
Betty J. Sternberg, Commissioner of Education

Appointed by the Governor:

John W. Rowe, M.D., Hartford, Chair
Louise M. Bailey, West Hartford, Secretary
Michael A Bozzuto, Cheshire
Peter S. Drotch, Framingham, Massachusetts
Linda P. Gatling, Southington
Lenworth M. Jacobs, M.D., West Hartford
Rebecca Lobo, Granby
Michael J. Martinez, East Lyme
Denis J. Nayden, Wilton
Thomas D. Ritter, Hartford
Wayne J. Shepperd, Danbury
Richard Treibick, Greenwich

Elected by alumni:

Philip P. Barry, Storrs
Andrea Dennis-LaVigne, Simsbury

Elected by students:

Salmun Kazerounian, Storrs
Stephen A. Kuchta, Storrs

June 30, 2004, marked the completion of the term of Richard Twilley of Hartford. Stephen A. Kuchta of Storrs succeeded him, effective July 1, 2004. His term ended June 30, 2006; Michael Nichols of Storrs succeeded him, effective July 1, 2006. Michael H. Cicchetti of Litchfield and David W. O'Leary of Waterbury resigned in Fall 2004; Peter S. Drotch of Framingham, Massachusetts and Rebecca Lobo of Granby, respectively, were appointed to serve the remainder of their terms.

William R. Berkley of Greenwich and Michael Nichols of Storrs completed their terms, effective June 30, 2005. They were succeeded by Michael A. Bozzuto of Cheshire and Salmun Kazerounian of Storrs, respectively, effective July 1, 2005. As noted above, Michael Nichols began a second term as a student trustee, effective July 1, 2006, as the successor to Stephen A. Kuchta of Storrs.

John G. Rowland served as Governor until he was succeeded by M. Jodi Rell, effective July 1, 2004. Bruce J. Gresczyk served as Commissioner of Agriculture until April 14, 2005; he was succeeded by F. Philip Prelli.

Public Act 05-255 increased the membership of the Board of Trustees from 19 to 21 members, effective July 1, 2005, adding the Commissioner of Economic and Community Development and the chairperson of the University of Connecticut Health Center Board of Directors as ex-officio members. The Commissioner of Economic and Community Development, James F. Abromaitis, was already serving as one of the 12 members appointed by the Governor; Wayne J. Shepperd of Danbury was appointed to fill the resulting vacancy.

Section 10a-104, subsection (c), of the General Statutes authorizes the Board of Trustees of the University of Connecticut to create a Board of Directors for the governance of the Health Center and delegate such duties and authority as it deems necessary and appropriate to said board of directors. The members of the Board of Directors as of June 30, 2006, were:

Ex officio members:

Philip E. Austin, President, University of Connecticut
J. Robert Galvin, Commissioner, Department of Public Health
Anne Gnazzo, Deputy Secretary, Office of Policy and Management

Appointed by the Chair of the Board of Trustees:

Gerard N. Burrow, Chair, Hamden
James F. Abromaitis, Unionville
Lenworth M. Jacobs, M.D., West Hartford

Appointed by the Governor:

John Bigos, Hartford
David B. Friend, M.D., Weston, Massachusetts
Jay L. Haberland, Simsbury

Members at Large:

Sanford Cloud Jr., Farmington
A. Jon Goldberg, West Hartford
Brian Hehir, Port Washington, New York
Robert Hennessey, Cheshire
Nancy J. Hutson, Stonington
Claire R. Leonardi, Long Lake, New York
David P. Marks, West Hartford
Robert T. Samuels, West Hartford
Ann Slaughter, Philadelphia, Pennsylvania

June 30, 2004, marked the completion of the term of Paul H. Johnson of Guilford. Robert Hennessey of Cheshire succeeded him, effective July 1, 2004. Thomas J. Devers, M.D., of New Britain resigned at the end of the 2004-2005 fiscal year. John Bigos of Hartford succeeded him.

June 30, 2005, marked the completion of the terms of Bruce Chudwick of Farmington, Aldrage B. Cooper of Skillman, New Jersey, and Gerard J. Lawrence, M.D., of Lyme. They were succeeded by Sanford Cloud Jr. of Farmington, Brian Hehir of Port Washington, New York, and Ann Slaughter of Philadelphia, Pennsylvania.

Marc S. Ryan served as Secretary of the Office of Policy and Management until he resigned. Robert L. Genuario, who was appointed to that position in January 2005, designated Deputy Secretary Anne Gnazzo to succeed him as the representative of the Office of Policy and Management on the Board of Directors.

Pursuant to Section 10a-108 of the General Statutes, the Board of Trustees of the University of Connecticut are to appoint a president of the University and the Health Center to be the chief executive and administrative officer of the University and the Health Center and of the Board of Trustees. Philip E. Austin served as President during the audited period.

The Health Center's Farmington complex houses the John Dempsey Hospital, the School of Medicine, the School of Dental Medicine, and related research laboratories. Additionally, the Schools of Medicine and Dental Medicine provide health care to the public, through the UConn Medical Group (including its UConn Health Partners unit) and the University Dentists, in facilities located at the Farmington campus and in neighboring towns.

The University of Connecticut Health Center Finance Corporation (Finance Corporation), a body politic and corporate, constituting a public instrumentality and political subdivision of the State, operates generally under the provisions of Title 10a, Chapter 187c of the General Statutes. The Finance Corporation exists to provide operational flexibility with respect to hospital operations, including the clinical operations of the Schools of Medicine and Dental Medicine.

The Finance Corporation is empowered to acquire, maintain and dispose of hospital facilities and to make and enter into contracts, leases, joint ventures and other agreements; it acts as a procurement vehicle for the clinical operations of the Health Center. The Hospital Insurance Fund (otherwise known as the John Dempsey Hospital Malpractice Fund), which accounts for a self-insurance program covering claims arising from health care services, is administered by the Finance Corporation in accordance with Section 10a-256 of the General Statutes. Additionally, Section 10a-258 of the General Statutes gives the Finance Corporation the authority to determine which hospital accounts receivable shall be treated as uncollectible.

The Finance Corporation acts as an agent for the Health Center. In the past, it operated on a "pass-through" basis; it did not accumulate any significant assets or liabilities. However, construction of the Health Center's new Medical Arts and Research Building, initiated during the previous audited period, was handled through the Finance Corporation. The building is an asset of the Finance Corporation and the associated debt a liability. Similarly, during the audited period, the Health Center's acquisition of the facility located at 16 Munson Road was handled through the newly incorporated UCHCFC Munson Road Corp., a wholly owned subsidiary of the Finance Corporation.

The Finance Corporation is administered by a Board of Directors, consisting of five members appointed under the provisions of Section 10a-253 of the General Statutes. The members of the Board of Directors as of June 30, 2006, and throughout the audited period, were:

Ex officio members:

Phillip E. Austin, Ph.D., President

Peter J. Deckers, M.D., Executive Vice President for Health Affairs

Gale Mattison, designee of the Secretary of the Office of Policy and Management

Appointed by the Governor:

John W. Rowe, M.D., of New York, New York, Chair

James F. Abromaitis, Unionville

Recent Legislation:

During the period under review, and thereafter, legislation was passed by the General Assembly affecting the Health Center. The most noteworthy items are presented below:

- Public Act 05-255, Section 1, effective July 1, 2005, increased the membership of the Board of Trustees from 19 to 21 members, adding the Commissioner of Economic and Community Development and the chairperson of the University of Connecticut Health Center Board of Directors as ex-officio members.
- Public Act 05-255, Section 2, effective July 1, 2005, authorizes the University to borrow money from the Connecticut Health and Education Facilities Authority (CHEFA) for projects at the Health Center and pledges revenue from Health Center clinical services projects to repay this borrowing. It authorizes CHEFA to back any bonds it issues for this purpose with a special capital reserve fund. Special capital reserve fund backed bonds are contingent liabilities of the State; if the reserve is exhausted, the General Fund automatically replenishes it, regardless of the State spending cap.
- Public Act 07-1, June Special Session, Section 123, effective June 26, 2007, authorized a special deficiency appropriation for the Health Center of \$22,100,000.

RÉSUMÉ OF OPERATIONS:

Over the last decade and more, changes in the statutes governing the State's constituent institutions of higher education gave the Health Center greater autonomy and flexibility. The most significant changes were effectuated by Public Act 91-256, effective July 1, 1991; subsequent legislation increased the degree of independence granted the institutions.

This independence is most notable with respect to procurement actions. Institutions of higher education may, under Section 10a-151b of the General Statutes, purchase equipment, supplies and services and lease personal property without review and approval by the State Comptroller, the Department of Administrative Services or the Department of Information Technology. Further, they are not subject to the restrictions concerning personal service agreements codified under Sections 4-212 through 4-219, although, as a compensating measure, personal service

agreements executed by the institutions of higher education must satisfy the same requirements generally applicable to other procurement actions.

Under Section 3-25 of the General Statutes, higher education institutions may, subject to the approval of the Comptroller, pay most non-payroll expenditures (those funded from the proceeds of State bond issuances being an exception) directly, instead of through the State Comptroller. The Health Center began issuing checks directly to vendors in August 1993. The checks are drawn on a “zero balance” checking account controlled by the State Treasurer. Under the approved procedures, funds are advanced from the Health Center’s civil list funds to the Treasurer’s cash management account. The Treasurer transfers funds from the cash management account to the “zero balance” checking account on a daily basis, as needed to cover checks that have cleared.

The Health Center also enjoys a significant degree of autonomy with respect to personnel matters. Section 10a-108 of the General Statutes grants the Board of Trustees the authority to employ professional employees and establish the terms and conditions of employment. Section 10a-154b allows institutions of higher education to establish positions and approve the filling of all position vacancies within the limits of available funds.

Public Act 95-230, known as “The University of Connecticut 2000 Act,” authorized a massive infrastructure improvement program to be managed by the University, effective June 7, 1995. Although subsection (c) of Section 7 of Public Act 95-230 provides that the securities issued to fund this program are to be issued as general obligations of the University, it also provides that the debt service on these securities is to be financed, for the most part, from the resources of the General Fund. However, as they are not considered to be a “state bond issue” as referred to in Section 3-25 of the General Statutes, the University is able to make payments related to the program directly, rather than process them through the State Comptroller.

The Health Center did not participate in this program when it was first established. However, when Public Act 02-3 of the May 9 Special Session authorized 1.3 billion dollars in new bond funds for the University, over \$300 million was earmarked for infrastructure improvements at the UConn Health Center.

Subdivision (1) of subsection (b) of Section 9 of Public Act 95-230 established a permanent endowment fund, the net earnings on the principal of which are to be dedicated and made available for endowed professorships, scholarships and programmatic enhancements. To encourage donations, subparagraph (A) of subdivision (2) of subsection (b) of Section 9 of the Act provided for State matching funds for eligible donations deposited into the fund, limiting the total amount matched to \$10,000,000 in any one year and to \$20,000,000 in the aggregate. It specified that the match, which was to be financed from the General Fund, would be paid into the fund during the fiscal years ending June 30, 1998, 1999 and 2000.

Effective July 1, 1998, Section 28 of Public Act 98-252 authorized the deposit of State matching funds in the University or in a foundation operating pursuant to Sections 4-37e and 4-37f consistent with the deposit of endowment fund eligible gifts. This provision was made to clarify the issue of whether State matching funds could become foundation assets or must be deemed assets of the associated constituent unit of higher education.

The enabling legislation for this program was subsequently amended to extend it through the fiscal year ending June 30, 2014; the State’s maximum commitment was set as an amount not exceeding ten million dollars for the fiscal year ending June 30, 1999, seven million five hundred thousand dollars for each of the fiscal years ending June 30, 2000, June 30, 2002, June 30, 2003, June 30, 2004, and June 30, 2005, five million dollars for the fiscal year ending June 30, 2001, ten million dollars for the fiscal years ending June 30, 2006, and June 30, 2007, and fifteen million dollars for the fiscal years ending June 30, 2008, to June 30, 2014, inclusive (see Section 10a-109c of the General Statutes). Further, the amending legislation, codified in Section 10a-109i of the General Statutes, reduced the State match, from a one-to-one ratio to a one-to-two ratio (one State dollar for two private dollars) beginning with the fiscal year ended June 30, 1999, except for eligible gifts amounts certified for the fiscal years ended June 30, 1999 and 2000, for which written commitments were made prior to July 1, 1997. The ratio was further reduced to a one-to-four ratio beginning with the fiscal year ended June 30, 2007; similar caveats were established providing for a one-to-two match for gifts made during the period from January 1, 2005 to June 30, 2005, and those made for the period prior to December 31, 2004, but ending before December 31, 2012, that involve multiyear commitments.

Statistics compiled by the University’s registrar showed the following enrollments in the Health Center’s credit programs during the audited period.

Student Status	Fall 2004	Spring 2005	Fall 2005	Spring 2006
Medicine - Students	318	318	319	319
Medicine – Residents	597	597	595	595
Dental – Students	167	167	166	166
Dental - Residents	99	99	95	95
Totals	1,181	1,181	1,175	1,175

Under the provisions of Section 10a-105, subsection (a), of the General Statutes, fees for tuition were fixed by the University’s Board of Trustees. The following summary shows annual tuition charges during the audited period.

Student Status	2004-2005			2005-2006		
	In-State	Out-of-State	Regional	In-State	Out-of-State	Regional
School of Medicine	\$13,800	\$31,400	\$20,700	\$15,870	\$36,110	\$23,805
School of Dental Medicine	11,089	28,421	16,639	12,752	32,684	19,128

During the audited period, the State Comptroller accounted for Health Center operations in:

- General Fund appropriation accounts.
- The University of Connecticut Health Center Operating Fund (Section 10a-105 of the General Statutes).

- The University of Connecticut Health Center Research Fund (Section 10a-130 of the General Statutes).
- The University Bond Liquidation Fund (Special Act 67-276, Section 26, and others - used for both the University and the Health Center).
- The University Health Center Hospital Fund (Section 10a-127 of the General Statutes).
- The John Dempsey Hospital Malpractice Fund (Section 10a-256 of the General Statutes).
- Accounts established in capital project and special revenue funds for appropriations financed primarily with bond proceeds.

The Finance Corporation maintains a separate accounting system. However, in the past virtually all of its activity and balances were mirrored in the University of Connecticut Health Center Operating and Hospital Funds. However, as noted above, this changed with the recent construction of the Health Center's new Medical Arts and Research Building and the acquisition of the facility located at 16 Munson Road. These buildings are assets of the Finance Corporation and the associated debt a liability.

A small activity fund, the Health Center Student Activity Fund, was associated with the Health Center during the audited period. The financial effect of this activity fund was negligible.

The Health Center's financial statements are prepared in accordance with all relevant Governmental Accounting Standards Board (GASB) pronouncements. The Health Center utilizes the proprietary fund method of accounting whereby revenue and expenses are recognized on the accrual basis. All revenues and expenses are subject to accrual.

GASB Statement No. 20, *Accounting and Financial Reporting for Proprietary Funds and Other Governmental Entities That Use Proprietary Fund Accounting*, states that proprietary activities may elect to apply the provisions of Financial Accounting Standards Board (FASB) pronouncements issued after November 30, 1989, that do not conflict with or contradict GASB pronouncements. The Health Center has not elected this option.

GASB Statement No. 47, *Accounting for Termination Benefits*, was effective for periods beginning after June 15, 2005. This statement requires employers to recognize a liability and expense for voluntary termination benefits when the termination offer is accepted and the amount of the benefits can be estimated. Any pension liability related to early retirement is the State's responsibility and therefore the Health Center did not record any liability except for an accrual for compensated absences related to an early retirement plan in the fiscal year ended June 30, 2003.

Net patient service revenues are reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Settlements are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods, as final settlements are determined.

Property and equipment acquisitions are recorded at cost. Betterments and major renewals are capitalized, and maintenance and repairs are expensed as incurred. Depreciation is provided over the estimated useful life of each class of depreciable asset and is computed using the straight-line method.

Health care providers and support staff of the Health Center are fully protected by State statutes from any claim for damage or injury, not wanton, reckless or malicious, caused in the discharge of their duties or within the scope of their employment (“statutory immunity”). Any claims paid for actions brought against the State as permitted by waiver of statutory immunity have been charged against the Health Center’s malpractice self-insurance fund. Effective July 1, 1999, the Health Center developed a methodology by which it could allocate malpractice costs between the Hospital, the UConn Medical Group and University Dentists. For the years ended June 30, 2005 and 2006, these costs are included in the statement of revenues, expenses and changes in net assets.

The Health Center’s financial statements are presented using a single column format. However, consolidating statements of net assets and of revenues, expenses and changes in net assets are presented as supplementary information.

The Health Center’s financial statements are adjusted as necessary and incorporated in the State’s Comprehensive Annual Financial Report. The financial balances and activity of the Health Center, including that of the John Dempsey Hospital, are combined with those of University and included as a proprietary fund.

The Health Center’s net assets balance increased by \$17,574,410 from \$230,569,010 as of June 30, 2004, to \$248,143,420 as of June 30, 2005. It increased again by \$6,485,178 to \$254,628,598 as of June 30, 2006.

Health Center employment grew slightly during the audited period. The Health Center’s human resources system showed 4,359, 4,533 and 4,638 full-time equivalent filled positions as of June 30, 2004, 2005 and 2006, respectively.

During the audited period, patient revenues were the Health Center’s largest source of revenue. Patient revenues, as reflected in the Health Center’s financial statements, aggregated \$348,799,319 and \$368,563,662 for the fiscal years ended June 30, 2005 and 2006, respectively. These amounts are net of eliminations of internal transactions between the primary institution and the John Dempsey Hospital. Such internal revenues aggregated \$11,042,139 and \$10,659,568 for the fiscal years ended June 30, 2004 and 2005, respectively.

John Dempsey Hospital patient revenues were the largest single component of Patient revenues. Such revenues totaled \$209,828,298 and \$224,239,947 (prior to the elimination of transactions between the primary institution and the John Dempsey Hospital) for the fiscal years ended June 30, 2005 and 2006, respectively. Other operations that generated significant patient revenues were the Correctional Managed Healthcare Program and the UConn Medical Group.

Under the Correctional Managed Healthcare Program, the Health Center entered into an agreement, effective August 11, 1997, with the Department of Correction to provide medical care to the inmates incarcerated at the State’s correctional facilities. Medical personnel at the

correctional facilities, formerly paid through the Department of Correction, were transferred to the Health Center's payroll.

Under the agreement, while the program was to be managed by the Health Center, the Commissioner of the Department of Correction retained the authority for the care and custody of inmates and the responsibility for the supervision and direction of all institutions, facilities and activities of the Department. The purpose of the program was to enlist the services of the Health Center to carry out the responsibility of the Commissioner for the provision and management of comprehensive medical care.

The agreement called for the Health Center to provide comprehensive medical, mental health and dental services and medical support services such as laboratory, pharmacy and radiology to Department of Correction inmates at a capitated, or fixed, cost. However, as actually implemented, the program functions on a cost reimbursement basis. This is recognized in a new memorandum of agreement executed in March 2006.

Patient revenues generated by the program, as reflected in the Health Center's financial statements, were \$83,398,842 and \$86,852,076 for the fiscal years ended June 30, 2005 and 2006, respectively. These amounts did not include in-kind fringe benefit support, which was classified as General Fund operating support.

The Health Center recorded a receivable from the General Fund of \$13,372,269 as of June 30, 2005. This amount reflected the excess, of cumulative program expenditures, recorded on the accrual basis, over funding transfers from the Department of Correction since the inception of the program. A receivable of \$11,208,612 was recorded as of June 30, 2006.

The UConn Medical Group functions similarly to a private group practice. Faculty clinicians provide patient services and receive incentive payments based on fees earned. UConn Medical Group Patient service revenues (prior to the elimination of transactions between the primary institution and the John Dempsey Hospital) totaled \$63,784,881 and \$65,258,208 for the fiscal years ended June 30, 2005 and 2006, respectively.

Other significant sources of revenue included State General Fund operating support, restricted grants and payments for the services of interns and residents. State General Fund operating support, as reflected in the Health Center's financial statements, totaled \$124,580,676 and \$130,527,835 for the fiscal years ended June 30, 2005 and 2006, respectively. These amounts included budgeted appropriations, in-kind fringe benefit support associated with those budgeted appropriations and in-kind fringe benefit support associated with the Correctional Managed Healthcare Program.

Restricted grant revenues, as reflected in the Health Center's financial statements totaled \$91,388,451 and \$91,264,963 for the fiscal years ended June 30, 2005 and 2006, respectively. Federal grants comprised the largest part of these revenues.

Under the Residency Training Program, interns and residents appointed to local health care organizations are paid through the Capital Area Health Consortium. The Health Center reimburses the Capital Area Health Consortium for the personnel service costs incurred and is, in turn, reimbursed by the participating organizations. Program revenues (prior to the elimination of

transactions between the primary institution and the John Dempsey Hospital) aggregated \$37,573,473 and \$37,486,043 for the fiscal years ended June 30, 2005 and 2006, respectively.

The Health Center did not hold significant endowment and similar funds balances during the audited period, as it has been the Health Center's longstanding practice to deposit funds raised with the University of Connecticut Foundation, Inc. The Foundation provides support for the University and the Health Center. Its financial statements reflect balances and transactions associated with both entities, not only those exclusive to the Health Center. A summary of the Foundation's assets, liabilities, support and revenue and expenses, as per those audited financial statements, follows:

	Foundation	
	Fiscal Year Ended	
	<u>June 30, 2005</u>	<u>June 30, 2006</u>
Assets	\$342,996,000	\$366,423,000
Liabilities	17,835,000	13,342,000
Net Assets	325,161,000	353,091,000
Support and Revenue	66,170,000	73,327,000
Expenses and Transfers	38,660,000	45,317,000

During the audited period, the Health Center entered into a public-private partnership with Health Resources International to operate an outpatient surgical facility on the Health Center's Farmington campus. This joint venture was the Farmington Surgery Center LLC, (FSC). Health Resources International, a privately held limited liability company, was formed in 1998 to develop ambulatory surgery centers and provide management consulting services. The Health Center's stated reasons for entering into the partnership were to "create better access to private capital in addition to minimizing financial risk" and to take advantage of Health Resources International's "long-standing and highly-regarded expertise in managing and operating free-standing surgery centers."

The FSC began operations during the fiscal year ended June 30, 2005. Net profits and losses were to be allocated 76 percent to the Health Center and 24 percent to Health Resources International.

The FSC was included in the Health Center's June 30, 2005, Statement of Net Assets as an investment with a value of \$174,535 (cash contributions to date of \$969,231 less allocated losses of \$794,696). During the fiscal year ended June 30, 2006, the FSC was treated as a component of the John Dempsey Hospital.

Anticipated revenues were not realized, and the FSC suffered significant losses. The Health Center purchased all minority interests in the company at the start of the 2006-2007 fiscal year, effectively dissolving the partnership. Though the FSC still exists as a legal entity, it ceased operations. The outpatient surgical facility continues to operate as part of the John Dempsey Hospital.

Initial funding for the FSC was provided by a \$1,200,000 cash contribution from Health Resources International. Subsequently, Health Resources International made additional cash contributions aggregating \$625,390, the Health Center contributed cash of \$2,780,744 and other investors contributed \$240,000. When the Health Center purchased all minority interests in the operation, \$1,652,500 of the \$1,825,390 contributed by Health Resources International was returned to the firm; the other minority investors received full refunds of the cash they contributed.

Basically, the Health Center and Health Resources International invested (net) cash in the amounts of \$4,673,244 and \$172,890, respectively, in the FSC. The partnership's net assets balance at termination was negligible.

The Health Center's financial condition deteriorated significantly after the end of the audited period. As of June 30, 2006, the Health Center had an unrestricted cash balance (cash not externally restricted or reserved for estimated malpractice liabilities) of over thirty million dollars. By the end of the 2006-2007 fiscal year, this balance had fallen approximately thirty-seven million dollars, creating a deficit of over six million dollars (before application of a twenty-two million, one hundred thousand dollar deficiency appropriation authorized by Public Act 07-01 of the June Special Session). The Health Center received additional support from the legislature effective with the 2007-2008 fiscal year. However, if current trends continue, that additional support does not appear to be sufficient. The Health Center will have to take action to increase revenues or reduce expenditures.

PROGRAM EVALUATION:

Under Section 2-90 of the General Statutes, each audit conducted by the Auditors of Public Accounts may include an examination of performance in order to determine effectiveness. During our current review, we noted the potential for improving the efficiency of the Health Center's Center of Laboratory Animal Care (CLAC) billing process.

CLAC Billing:

Criteria: When personal service costs are a critical factor, automation, i.e., reducing the need for manual intervention in a process, can be an effective cost saving measure.

Condition: Services are provided by the Health Center's Center of Laboratory Animal Care (CLAC) based on requisitions filed by researchers. CLAC invoices the researchers on a monthly basis. Upon receipt of the invoices, the researchers approve the charges and identify the accounts to be charged. CLAC administrators then process the charges through the Health Center's accounting system.

It would be more efficient to streamline the workflow by entering the accounts to be charged in CLAC's billing system at the requisition stage. Charges could then be processed automatically through the Health Center's accounting system as they accumulate – as is the practice for charges assessed by other Health Center

service centers. Control is provided by after-the-fact account holder review of charges posted to the accounts they are responsible for.

Effect: The current process requires an unnecessary degree of manual intervention.

Cause: The Health Center has been making efforts to improve the CLAC billing process; the change outlined above would be an additional enhancement.

Recommendation: The Health Center should enter the accounts to be charged in CLAC's billing system at the requisition stage and process charges against those accounts as they accumulate. (See Recommendation 10.)

Agency Response: "Management is in agreement with the Auditor's recommendation that accounts to be charged by CLAC for services provided should be entered at the time of request for services, and that charges should be assessed against these accounts as they accumulate. After-the-fact review of charges by the account holder will provide the necessary review of the charges for accuracy.

CLAC billing system and process improvements will be considered for implementation within the context of other impending systems and process changes that affect the broader research area. A probable date for implementation of a change will be determined following the assessment of the extent of the changes necessary to the system and/or the impact of the change on CLAC's customers."

CONDITION OF RECORDS

Our review of the financial records of the Health Center disclosed certain areas requiring attention, as discussed in this section of the report.

Faculty Workload Standards:

- Criteria:* Quantified faculty workload standards can enhance accountability for the use of resources, aid in determining the relative contribution to institutional objectives of the various operating units and individuals and serve as a foundation for fair and equitable performance evaluations. Developing such standards will be difficult, considering the Health Center's overlapping mixture of educational, clinical (which encompasses the dual objectives of financial support for the institution and public service) and research functions. However, the information provided will be critical for informed decision making, given the current scarcity of resources.
- Condition:* The Health Center has not developed quantified faculty workload standards. Instead, faculty establish "CREAM" (Clinical, Research Education, Administration, Miscellaneous) profiles with their department heads on an annual basis. Each faculty member's profile is unique and the expectations within each domain of the profile vary significantly. This is expressed on a percentage of time basis and forms the basis for the goals and objectives for each individual's activities for the year.
- Effect:* Developing performance metrics in this manner can provide advantages in terms of personal growth and the opportunity to best integrate each faculty member's particular talents with the institution's mission. However, it does not provide comparability or allow for a determination of the "cost-benefit" of unit operations or individual efforts. Additionally, varying expectations can result in inequitable evaluations.
- Cause:* The Health Center has historically addressed faculty performance on an individualized basis.
- Recommendation:* The Health Center should develop quantified faculty workload standards. (See Recommendation 1.)
- Agency Response:* "As noted, a "CREAM" profile is established with each faculty member with his or her department head on an annual basis. This profile sets forth the expected percentage distribution of a faculty member's effort to clinical, research, educational, administrative and miscellaneous activity. Separate and apart from the CREAM profile, faculty members are evaluated annually under the

applicable faculty compensation plans which recognize meritorious effort for education, research and clinical activity. These plans are administered under the direction of a senior faculty member in accordance with a pre-established set of written principles and guidelines. Each plan identifies specific criteria for determining individual merit and performance criteria which must be met for the recognition of education and research contribution and clinical incentive. These plans include the Academic Merit Plan, Basic Science Merit Plan and Clinical Incentive Plan. Through these plans the Health Center recognizes individual contribution against pre-established criteria and expectations.”

*Auditors’ Concluding
Comments:*

The Academic Merit Plan and the Basic Science Merit Plan are qualitative, rather than quantitative in nature. The Clinical Incentive Plan provides a modest supplement to a clinician’s base salary based on clinical revenues collected; it does not set faculty workload standards. We are recommending the establishment of minimum standards that faculty would be expected to meet expressed in quantitative terms such as instructional hours, external grant funding obtained, clinical revenues collected, etc.

Requests for Proposals:

Criteria:

A request for proposal (RFP) should provide a clear and accurate representation of the business need the organization is attempting to satisfy. It should clearly describe what the organization wishes to acquire – it should not include extraneous requirements that preclude competition without adding value.

Condition:

In August 2006, the Health Center advertised for a “combination of wetlab space and office space with a minimum of 50,000 sq. ft of wet lab and associated lab support ... Within 1 mile radius of the University of Connecticut Health Center.” However, after a property was acquired, another RFP was issued for, essentially, the gutting and complete rebuilding of the property (at a cost several times that of the original acquisition).

Obviously, the Health Center did not need a property with existing wetlab space – it ripped out the existing wetlab space in the property it did acquire. The requirement for existing wetlab space served only to restrict competition by establishing criteria that only one property could meet.

Effect:

Including inappropriately restrictive language in the RFP limited the Health Center’s ability to consider alternatives and may have resulted in higher costs through reduced competition. A properly

worded RFP might have brought viable alternatives not previously considered to the Health Center's attention.

Cause: It appears that management decided to purchase the property in question before the RFP was issued. In other words, the RFP seems to have been written in a manner that "targeted" that specific property.

Recommendation: The Health Center should make sure that requests for proposals clearly describe the actual business need to be satisfied and do not restrict competition by including criteria that are not relevant. (See Recommendation 2.)

Agency Response: "We agree with the recommendation."

Execution of Contracts:

Criteria: Contractors should not be authorized to begin work prior to execution of a contract. Formal written agreements establishing rights and responsibilities are a safeguard for all parties involved.

Condition: In December 2001, the Health Center promulgated new contracting procedures. According to these procedures, "New contracts must be fully executed prior to the beginning of work." However, it appears that this requirement is largely disregarded in practice.

Per our analysis of the Health Center's contract management database, 405 personal service agreements were executed by the Health Center during the period from March 1, 2006 through June 30, 2007. Fifteen of the 220 research related agreements were amendments of existing contracts, 194 of the remaining 205 were signed after the start date. Delays ranged from two to 787 days; the average lag time was 120 days. One hundred and twenty-two of the other 185 agreements were signed after the start date. Delays ranged from four to 1,487 days; the average lag time was 104 days. The delays were calculated by comparing the contract start date to the date the contracts were signed by a representative of the Health Center.

We also reviewed 25 contracts executed through the Finance Corporation. Nine of the 25 were signed after the start date. Delays ranged from 19 to 116 days; the average lag time was 48 days.

Effect: Unforeseen liabilities may be incurred if work is started on a project before all of the key terms have been agreed to and the contract has been signed, especially if disagreements arise regarding the nature or quality of the work involved.

Cause: Those responsible for initiating the process did not allow sufficient lead-time. The magnitude of the time lags involved indicates that, in at least some instances, initiation of the process may have been delayed until the need to process payments to contractors became apparent (payments are not processed until a contract is in place).

It is noteworthy that letters mailed to prospective contractors include a warning that the Health Center is not liable for payment until contracts are executed and goes on to emphasize that contracts must be executed “prior to the expiration date of the agreement.” These letters should state that contracts must be executed before the contractors can commence working.

Recommendation: The Health Center should not authorize contractors to begin work prior to the execution of a contract. (See Recommendation 3.)

Agency Response: “Management agrees and continues to put in place processes that will continue to improve the process. UCHC has and continues to communicate to departments the policies necessary to prepare and circulate documents to develop a personal services contract that would be sent to prospective contractors for their signature prior to execution. Our procedures on our website also indicate that we will not prepare the necessary paperwork for a personal services contract that has a retrospective effective date or an effective date that cannot be met prior to the contract’s full execution. It also states that no contracted service may begin prior to a fully executed contract. In addition, recent vacancies have provided an opportunity to reorganize that has resulted in the Associate Vice President of Research Finance to assuming responsibility for the Research Administration Pre-Award department which will lead to improved coordination of contracting for research. The Finance Corporation procedures were revised December 19, 2005. In addition, the Finance Corporation has restructured functions with the recent hiring of a new Administrative Manager, who will report to the Controller. The job description has been revised to emphasize contracting; accounting functions were moved to other positions.

As stated above improvements are being made and in no cases were any payments made to contractors until such time as the agreement was executed.”

Reemployed Retirees:

Criteria: Wages paid should be appropriate for the work performed. They should be comparable to those of other staff members with equivalent responsibilities performing similar tasks. They should

not be based on the salary that an employee received in the past while serving in a position of substantially greater responsibility.

Condition: Generally, the Health Center pays reemployed retirees at their salary level at termination. This is not appropriate for some employees, such as those formerly holding administrative positions, as they will not have the same responsibilities as they did prior to retirement.

Effect: Reemployed retirees may be paid at a higher rate of pay than is reasonable for the work they are performing.

Cause: Reemployed retirees have traditionally been paid at their salary level at termination.

Recommendation: The Health Center should set reemployed retirees' salaries based on the work they are engaged to perform, not their salary level at termination. (See Recommendation 4.)

Agency Response: "We agree with the recommendation to set reemployed retirees' salaries based on the work they are engaged to perform."

Procurement Policies/Procedures:

Criteria: There should be one set of uniform procurement policies in order to provide all employees with a clear understanding of the process to be followed.

Condition: The Health Center has two main alternatives for procurement actions, acting in its own name under the authority of Section 10a-151b of the General Statutes and through the Finance Corporation. The Health Center is in the process of revising its procurement policies/procedures (within the existing statutory framework) for actions undertaken under the authority of Section 10a-151b. This presents an opportunity for devising a unified set of policies and procedures that address all procurement actions by incorporating Finance Corporation procurement actions into the new policies/procedures.

Effect: Having two disparate, but overlapping, sets of procurement policies/procedures can cause confusion and result in inconsistencies.

Cause: The Finance Corporation was created to provide needed flexibility with respect to procurement actions before statutory changes granted the State's institutions of higher education their current degree of autonomy in this area.

Recommendation: The Health Center should incorporate Finance Corporation procurement actions into the latest revision of its procurement policies/procedures. (See Recommendation 5.)

Agency Response: “The Health Center has procurement policies/procedures for the Finance Corporation and the Health Center. The current revisions will include the Finance Corporation. In addition, the Finance Corporation’s polices and procedures will be added to the web site.”

Finance Corporation Procurement:

Criteria: Purchasing policies and procedures should be designed to encourage a strong element of competition. Free market forces, acting in an open and competitive environment, are vital to an efficient and cost effective procurement process.

Condition: In our previous report, we recommended that Finance Corporation policies and procedures for purchasing and contracting be revised to enhance competition and accountability. Internal control was improved significantly; the December 19, 2005, revision of the policies and procedures added a requirement that items over \$250,000 be reported to the Health Center's Finance Subcommittee and items greater than \$500,000 be approved by the Health Center's Board of Directors. Additionally, the chief financial officer's approval is now required for non-competitive procurement actions.

However, the policies and procedures still describe “Open or Competitive Bidding” as “any impartial process whereby hospital facilities type A, hospital facilities type B, joint ventures or shared service agreements which are to be contracted for by the corporation are evaluated.” They go on to state that “This process may include solicitations to bid, pre-qualification of bidders, review of written proposals, pre-bid meetings, oral presentations, sealed bids, negotiation or any combination thereof.” Basically, the policies and procedures still describe certain key elements of a fully competitive selection process as optional.

Effect: This could result in higher costs through reduced competition or, potentially, create the impression that contract steering has occurred.

Cause: The policies and procedures for purchasing and contracting were designed for maximum flexibility.

Recommendation: The Health Center should revise Finance Corporation policies and procedures for purchasing and contracting to mandate that all

competitive procurement actions include the open and public solicitation and consideration of bids or proposals as standard practice. Further, all non-competitive procurement actions should be reported to the Boards of the Finance Corporation and the Health Center. (See Recommendation 6.)

Agency Response:

“The current policies and procedures for purchasing and contracting of the Finance Corporation were established and follow the guidelines set forth in Section 10a-250 et seq. of the Connecticut General Statutes. Current policies and procedures provide for competitive bidding, which is used extensively. In addition, the Board of Directors approves all contracts and purchases over \$250,000. This provides for a much greater level of review and approval than the policy for all other University transactions; the overall University threshold for Board approval is \$500,000. Finally, specific medical needs may dictate the use of the sole source mechanism. It is precisely for this reason that the Finance Corporation was created.”

*Auditors’ Concluding
Comments:*

Our recommendation is in accord with Section 10a-250 et seq. of the General Statutes. We agree that it, in certain circumstances, a competitive selection process may not be the best way to handle purchasing and contracting. However, because of the innate potential for abuse, all procurement actions that are not competitive in nature should be reported to the Boards of the Finance Corporation and the Health Center, even if they are less than \$250,000 in amount. The report should, of course, disclose the reasons why a competitive selection process wasn’t followed.

Further, the policies and procedures adopted by the Finance Corporation’s Board of Directors in accordance with Section 10a-255 allow a procurement action to be defined as competitive even when it was not bid competitively. We believe public solicitation of competitive bids is an essential element of a competitive procurement action and that all procurement actions lacking this element should be acknowledged to be non-competitive and reported to the Boards of the Finance Corporation and the Health Center.

Access Control:

Criteria:

Staff should be given access to automated processing systems only to the extent they need it to perform their assigned functions. In order to preserve adequate segregation of duties, no single individual should have control over all phases of a transaction.

Condition: In our prior review, we found that, though procedures in force call for a one-time notification by Human Resources when employees terminate, there is no regular comparison of those given access with the roster of current employees. This condition continues.

Additionally, in our prior review, we noted that administrators familiar with assigned staff and their access needs did not regularly review financial reporting system data access templates. During our current review, we found that attempts to institute such a review had not been successful, as the systems involved were not capable of generating access reports in a user-friendly format. This problem did not affect the human resources system, as data access templates were maintained by an administrator familiar with assigned staff.

Effect: Allowing any unnecessary access to critical systems has the potential to weaken internal control.

Cause: There does not seem to be any significant obstacle to developing an automated comparison of access templates to the roster of current employees. Developing a user-friendly access report will present difficulties because of the complexities of the systems involved and because the system generated reports (basically printouts of the access templates) cannot be readily converted to a user-friendly format on an automated basis.

Recommendation: Listings of individuals given access to critical automated processing systems should be regularly compared to the roster of current employees; efforts to develop a user-friendly access report to facilitate reviews of staff access rights by administrators should be continued. (See Recommendation 7.)

Agency Response: “Management agrees and work has been ongoing to meet the recommendation. The Accounting department is working on creating a database to develop the recommended report in a user-friendly format. A draft report is scheduled to be reviewed by a test group of department managers in October 2007, using September 30, 2007 data.”

Virtual Tags:

Criteria: Capital assets should be physically inspected periodically to verify the accuracy of inventory records.

Condition: The Health Center conducts physical inventories by scanning bar coded tags affixed to equipment items. Some capitalized items, such as software licenses, cannot be tagged (they are assigned

“virtual tags” when they are entered into the inventory control system).

The existence of these items can usually be verified by examination of paperwork associated with their acquisition. However, when we conducted a physical inventory of equipment, on a test basis, we had problems verifying the existence of some virtually tagged items, as the associated paperwork was no longer readily available.

Effect: It can be difficult to verify the existence of untagged capital equipment items.

Cause: Non-current procurement documentation is not always readily accessible.

Recommendation: The Health Center should maintain a file of the documentation establishing the existence of all capitalized items that cannot be readily verified by physical inspection. (See Recommendation 8.)

Agency Response: “Management agrees and has developed a database to track all virtual tagged items in the fixed asset system. In addition, the Accounting department will create a PDF file that contains all back-up documentation for each item labeled by a tag number. This was started in July for fiscal year 2008.”

Student Labor:

Criteria: Student labor positions should be publicly posted and filled through an open and equitable process to avoid favoritism or the appearance thereof.

Condition: We noted that student labor positions were being filled at the department level. The Health Center’s Human Resources department was told which individual was to be hired at the point a request to establish the position was filed. It is our understanding that the Human Resources department intends to change this process.

Effect: The method by which students were selected during the audited period could result in inequities, as all qualified individuals were not given the opportunity to compete for open positions.

Cause: The award of these positions has traditionally been a departmental prerogative.

Recommendation: The Health Center should implement procedures to make the award of student labor positions a more open and equitable process. (See Recommendation 9.)

Agency Response: “To ensure adherence to hiring policy for the hiring of student labor, HR will survey the departments to determine their summer needs beginning in the early spring of each year. HR will disseminate hiring policy to clarify the process for hiring student labor at that time. HR will post open continuous positions for summer employment during the months of March and April and refer applicants to the departments for interviewing and selection.”

Institutional Base Salary:

Criteria: The NIH Grants Policy Statement indicates that bonus funds and incentive payments are “allowable as part of a total compensation package, provided such payments are reasonable and are made according to a formal policy of the grantee that is consistently applied regardless of the source of funds.” This total allowable compensation, generally referred to as “institutional base salary,” consists of those amounts paid for personal services that can be allocated to research awards based on the percentage of time and effort devoted by a researcher. Institutional base salary includes certain incentive payments as well as a researcher’s regular or “base” salary.

Condition: The Health Center doesn’t include any incentive payments in institutional base salary; administrators took this conservative approach to avoid inadvertently violating Federal guidelines. The two most significant incentive payments paid by the Health Center are research incentives (related to the amount of salary a researcher manages to charge to external awards) and clinical incentives (related to collections on patient billings) payments. It seems clear that current practice is correct with respect to research incentive payments. They shouldn’t be included as they are dependent on the funding source to which a researcher’s salary is charged, not the work actually being performed.

However, clinical incentive payments are compensation for work actually performed. They should be included in institutional base salary.

Effect: Including clinical incentive payments in institutional base salary could, potentially, result in a modest increase in recoveries on externally funded awards.

Cause: There are many different types of incentive payments. It can be difficult to determine whether or not a given type of incentive

payment can legitimately be included in institutional base salary. Health Center administrators felt it was prudent to exclude all incentive payments from institutional base salary.

Recommendation: The Health Center should include clinical incentive payments in institutional base salary. (See Recommendation 11.)

Agency Response: “UMG Management is currently evaluating the clinical incentive plan. The first draft of a revised plan proposes moving to a system that incorporates some of the qualities of the academic merit plan. Therefore, if the revised plan were adopted it would add the amount determined from the new incentive plan to institutional base salary. However, if the incentive program were to continue as a payment that does not get included in the base salary, the amounts that could possibly be recovered would be not be significant because many of the clinical faculty have little or no research activity or in some instances, exceed the NIH salary cap.”

Auditors’ Concluding Comments: We acknowledge that including clinical incentive payments in institutional base salary could not result in more than a modest increase in recoveries. However, as there is no associated cost, even a small increase would be beneficial.

Compensatory Time:

Criteria: Compensatory time is intended to provide management with a useful tool for addressing relatively short-term workload fluctuations. The existence of large balances that are not used in a timely fashion may be indicative of staffing problems.

Condition: We noted that some Health Center employees had accumulated large compensatory time balances. Further, the number of employees with large accumulations appears to be increasing. In previous reviews, we found that 15 employees had balances of 400 hours or more as of March 27, 2002, and 31 employees had balances of 400 hours or more as of June 17, 2005. As of July 5, 2007, 38 employees had balances of 400 hours or more. One employee had accumulated more than 961 hours.

Effect: Allowing the accumulation of large compensatory time balances can lead to problems when the balances are used by employees or paid out on termination. Protracted absences can put an additional strain on the agency’s workforce; large termination payments can create a financial burden.

Cause: The accumulation of large compensatory time balances may reflect staffing problems.

Recommendation: The Health Center should improve control over compensatory time by addressing the accumulation of large balances. (See Recommendation 12.)

Agency Response: “The majority of the employees with high compensatory time are members of UHP. This contract permits the selection of compensatory time in lieu of overtime pay, which contributes to higher balances. The recently negotiated contract with UHP allows employees to request pay out of compensatory time balances to help to reduce this liability. HR will continue to produce reports and will disseminate them to management so that compensatory time balances and staffing levels can be monitored by the respective managers.”

Faculty Time and Attendance Reports:

Criteria: Centralization of time and attendance recordkeeping improves control and enhances accountability.

Condition: Non-faculty Health Center employees submit time and attendance reports to the Payroll Department on a biweekly basis. As has been discussed in prior audit reports, though many faculty members accumulate compensated absences (vacation), most of those faculty members do not submit any report of attendance or leave to the Payroll Department. The official records of faculty vacation balances are “calendars” submitted to the Dean’s offices on an annual basis.

The degree of control exercised in this area by employing departments varies. Some apparently place the responsibility for maintaining leave records solely on the faculty members themselves, requiring them to complete and submit “calendars” on an annual basis. When a faculty member retires, the appropriate Dean’s office informs the Personnel Department of the faculty member’s accumulated balance. After reviewing a faculty member’s vacation leave record, the Human Resources Department then directs the Payroll Department to pay the faculty member for the unused time. We have been informed that this procedure would apply even to those faculty members that do regularly submit time and attendance reports to the Payroll Department. The “calendars” are considered the official records for these employees, not the centralized time and attendance records.

Effect: The lack of a uniform control structure mandating regular reporting of time and attendance for recording in a centralized recordkeeping system lessens the assurance the Health Center can have that amounts paid are correct. Additionally, as “calendars”

are submitted on a calendar year basis, the Health Center's liability for faculty members' compensated absences at fiscal year end must be based on an estimate of accumulated balances.

Cause: Though the Health Center has historically accounted for faculty members' compensated absences in this manner, we could not readily ascertain why. Though management responded negatively to our prior recommendation addressing this control deficiency, the response did not cite any obstacles to converting or benefits accruing from the current system.

Recommendation: The Health Center should require all employees that accumulate compensated absences to submit biweekly attendance reports to the Payroll Department. (See Recommendation 13.)

Agency Response: "A change in the current process for tracking compensated absences is not recommended at this time. The Health Center will continue to collect this data through the Dean's offices where they are recorded, reviewed, and approved, and sent to payroll for payment."

Auditors' Concluding Comments: As noted above, though management responded negatively to our prior recommendation addressing this control deficiency, the response did not cite any obstacles to converting or benefits accruing from the current system. Management reiterated that response verbatim when we repeated our recommendation in our current report. Again, including all employees that accumulate compensated absences in the centralized time and effort recordkeeping system would improve internal control; management does not cite any obstacles to converting or give any reasons why the current system is considered preferable.

Other Audits:

The John Dempsey Hospital, the Finance Corporation and the UConn Medical Group were audited by public accounting firms during the audited period. Combined management letters were issued each year communicating the recommendations developed as a result of their audits. They recommended the following:

Fiscal year ended June 30, 2005:

Comments repeated from the 2004 management letter:

1. Post dental clinic receipts to the detailed accounts receivable records in a timely manner, review the adequacy of the new dental clinic billing and collection system and consistently follow policies and procedures regarding the authorization of dental patient charts. These comments were repeated from the 2004 management letter.

2. Improve the reconciliation process intended to validate the data accumulated in the system used to calculate bad debt and contractual allowance.
3. Consider certain factors that could potentially affect the Health Center's malpractice liability calculation.
4. Consider utilizing an inventory tracking system to maintain inventory prices for specific medical supply items, apply the policies and procedures developed for the hospital to all departments and perform a comprehensive analysis to determine the amount of an obsolescence reserve.
5. Resolve reconciliation issues related to the implementation of the State's new accounting system (CORE).
6. Improve documentation supporting manual journal entries.
7. Ensure that information technology policies and procedures under development provide for adequate access controls and adequate testing of changes/enhancements in automated data processing systems.

New Comments Not in the 2004 Management Letter:

8. Monitor capital asset acquisitions and adjust as necessary for timing differences between the dates when capital assets are acquired and put in use and the dates when payment is made for such assets.
9. Test backup systems and restoration procedures to make sure they work properly.
10. Improve controls designed to restrict physical access to the data center.
11. Improve controls designed to prevent inappropriate access to certain data processing systems.

Fiscal year ended June 30, 2006:

Comments repeated from the 2005 management letter:

1. Resolve reconciliation issues related to the implementation of the State's new accounting system (Core-CT).

New Comments Not in the 2005 Management Letter:

2. Require dual signatures prior to issuance for disbursements over a predetermined amount instead of allowing the checks to be issued with a single signature – subject to a post-issuance review by a second authorized signatory.
3. Correct a condition (payments posted against the proper invoice but cash applied to the oldest balance related to the aging report) that creates inaccuracies in the Dental Clinics accounts receivable aging.
4. Provide adequate training to the Dental staff to ensure that medical charts include all necessary information to support charges.
5. Improve control over and documentation of modifications of the accounting and human resources system software.
6. Limit access to the healthcare contract management software to the appropriate level.
7. Improve control over and documentation of the testing and approval of modifications of the healthcare contract management software.

Other Matter:

The United States Department of Agriculture (USDA) routinely conducts inspections of animal research laboratories around the country. During November 2005, March, 2006, August 2006, October 2006, and January 2007, the USDA conducted inspections of the animal research laboratory at the Health Center. As a result of these inspections, the Health Center was cited for violating certain provisions of the Federal Animal Welfare Act. The most serious violations involved deficiencies in the care and handling of nonhuman primates.

During July 2007, the United States Department of Agriculture (USDA) fined the Health Center \$5,532 for violations of the Federal Animal Welfare Act. In addition, during January 2008, The National Institutes of Health asked the Health Center to return \$65,005 in grant funds because of these violations. We were informed that the Health Center is not contesting the request to return these funds, but is appealing the amount.

It is our understanding that the Health Center is not currently conducting research using nonhuman primates. Additionally, we were informed that a new part-time position for a research compliance monitor for animal care is in the process of being approved. The duties of the position are to identify whether research personnel are conducting animal research in accordance with State and Federal regulations and approved protocols.

As part of our review, we examined inspections of laboratory operations at the Health Center and noted that:

- In July 2007, the Council on Accreditation of the Association for Assessment and Accreditation of Laboratory Animal Care (AAALAC International) informed the Health Center that its program conforms with AAALAC International standards, as set forth in the Guide for the Care and Use of Laboratory Animals, NRC 1996. It stated that full accreditation would, therefore, continue. It should be noted that AAALAC is the only accrediting body recognized by the Public Health Service, a division of the U.S. Department of Health and Human Services.

Results of inspections performed by the USDA during October 2007 and April 2008, did not disclose any significant deficiencies. We did note, however, that some exceptions were identified that appeared to be minor in nature.

RECOMMENDATIONS

Status of Prior Audit Recommendations:

In our previous report on our audit examination of the Health Center, we presented nine recommendations pertaining to Health Center operations. The following is a summary of those recommendations and the actions taken thereon:

- Prepare a cost/benefit analysis documenting the value of the dental program to the State – an analysis was prepared and presented to the Board of Directors.
- Thoroughly document all procurement actions – management has acknowledged the importance of such documentation; formal procurement policies are being drafted.
- Enhance Finance Corporation policies and procedures for purchasing and contracting – internal control was improved; this recommendation has been restated and repeated. (See Recommendation 6.)
- Don't authorize contractors to begin work prior to execution of a contract – we continued to find significant delays. (See Recommendation 3.)
- Limit access to critical automated processing systems as necessary to provide for adequate segregation of duties and provide access only to those that currently need it – the Health Center has made efforts to comply with this recommendation; it has been restated and, in part, repeated. (See Recommendation 7.)
- Maintain a current, comprehensive written disaster recovery plan that provides for offsite backup of critical data and upgrade data center surge protection – we found that a disaster recovery plan had been formulated and that the data center surge protection upgrade was in progress; management reviewed backup strategies and decided that offsite backup of critical data wasn't necessary.
- Tag equipment when it is delivered to the Health Center Campus, reconcile equipment expenditures to the aggregate change in equipment inventory valuation, and consider using RFID tags instead of bar coded tags – new tagging procedures have been implemented (we were informed that approximately 50 percent of new equipment is now tagged at the dock); the Health Center plans to institute a detailed comparison of equipment expenditures with additions to inventory for the fiscal year ended June 30, 2007; management has determined that RFID tags are currently cost prohibitive, but continues to monitor the technology.
- Improve control over compensatory time by addressing the accumulation of large balances – this recommendation has been repeated. (See Recommendation 12.)
- Require all employees that accumulate compensated absences to submit biweekly attendance reports to the Payroll Department – this recommendation has been repeated. (See Recommendation 13.)

Current Audit Recommendations:

1. The Health Center should develop quantified faculty workload standards.

Comment:

Quantified faculty workload standards can enhance accountability for the use of resources, aid in determining the relative contribution to institutional objectives of the various operating units and individuals and serve as a foundation for fair and equitable performance evaluations.

2. The Health Center should make sure that requests for proposals clearly describe the actual business need to be satisfied and do not restrict competition by including criteria that are not relevant.

Comment:

We noted that an RFP issued in connection with a recent acquisition of property in Farmington included inappropriately restrictive (only a single property met the advertised criteria) language. This apparent “targeting” of a specific property limited the Health Center’s ability to consider alternatives and may have resulted in higher costs through reduced competition.

3. The Health Center should not authorize contractors to begin work prior to the execution of a contract.

Comment:

Per our analysis of the Health Center’s contract management database, 418 personal service agreements were executed by the Health Center during the period from March 1, 2006 through June 30, 2007. Fifteen of the 220 research related agreements were amendments of existing contracts, 194 of the remaining 205 were signed after the start date. Delays ranged from two to 787 days; the average lag time was 120 days. One hundred and twenty-two of the other 185 agreements were signed after the start date. Delays ranged from four to 1,487 days; the average lag time was 113 days.

We also reviewed 25 contracts executed through the Finance Corporation. Nine of the 25 were signed after the start date. Delays ranged from 19 to 116 days; the average lag time was 48 days.

- 4. The Health Center should set reemployed retirees' salaries based on the work they are engaged to perform, not their salary level at termination.**

Comment:

Generally, the Health Center pays reemployed retirees at their salary level at termination. This is not appropriate for some employees, such as those formerly holding administrative positions, as they will not have the same responsibilities as they did prior to retirement.

- 5. The Health Center should incorporate Finance Corporation procurement actions into the latest revision of its procurement policies/procedures.**

Comment:

The Health Center is in the process of revising its procurement policies/procedures (within the existing statutory framework) for actions undertaken under the authority of Section 10a-151. This presents an opportunity for devising a unified set of policies and procedures that address all procurement actions by incorporating Finance Corporation procurement actions into the new policies/procedures.

- 6. The Health Center should revise Finance Corporation policies and procedures for purchasing and contracting to mandate that all competitive procurement actions include the open and public solicitation and consideration of bids or proposals as standard practice. Further, all non-competitive procurement actions should be reported to the Boards of the Finance Corporation and the Health Center.**

Comment:

Recent revisions have significantly enhanced internal control. However, the policies and procedures still describe "Open or Competitive Bidding" as "any impartial process whereby hospital facilities type A, hospital facilities type B, joint ventures or shared service agreements which are to be contracted for by the corporation are evaluated." They go on to state that "This process may include solicitations to bid, pre-qualification of bidders, review of written proposals, pre-bid meetings, oral presentations, sealed bids, negotiation or any combination thereof." Basically, the policies and procedures still describe certain key elements of a fully competitive selection process as optional.

- 7. Listings of individuals given access to critical automated processing systems should be regularly compared to the roster of current employees; efforts to develop a user-friendly access report to facilitate reviews of staff access rights by administrators should be continued.**

Comment:

Though procedures in force call for a one-time notification by Human Resources when regular employees (but not “special” employees such as reemployed retirees) terminate, there is no regular comparison of those given access with the roster of current employees. Additionally, we noted that administrators familiar with assigned staff and their access needs did not regularly review data access templates. During our current review, we found that attempts to institute such a review had not been successful, as the systems involved were not capable of generating access reports in a user-friendly format.

- 8. The Health Center should maintain a file of the documentation establishing the existence of all capitalized items that cannot be readily verified by physical inspection.**

Comment:

The Health Center conducts physical inventories by scanning bar coded tags affixed to equipment items. Some capitalized items, such as software licenses, cannot be tagged (they are assigned “virtual tags” when they are entered into the inventory control system).

The existence of these items can usually be verified by examination of paperwork associated with their acquisition. However, when we conducted a physical inventory of equipment, on a test basis, we had problems verifying the existence of some virtually tagged items, as the associated paperwork was no longer readily available.

- 9. The Health Center should implement procedures to make the award of student labor positions a more open and equitable process.**

Comment:

Student labor positions should be publicly posted and filled through an open and equitable process to avoid favoritism or the appearance thereof. However, we noted that student labor positions were being filled at the department level. The Health Center’s Human Resources department was told which individual was to be hired at the point a request to establish the position was filed. It is our understanding that the Human Resources department intends to change this process.

10. The Health Center should enter the accounts to be charged in CLAC's billing system at the requisition stage and process charges against those accounts as they accumulate.

Comment:

Services are provided by the Health Center's Center of Laboratory Animal Care (CLAC) based on requisitions filed by researchers. CLAC invoices the researchers on a monthly basis. Upon receipt of the invoices, the researchers approve the charges and identify the accounts to be charged. CLAC administrators then process the charges through the Health Center's accounting system.

It would be more efficient to streamline the workflow by entering the accounts to be charged in CLAC's billing system at the requisition stage. Charges could then be processed automatically through the Health Center's accounting system as they accumulate – as is the practice for charges assessed by other Health Center service centers. Control is provided by after-the-fact account holder review of charges posted to the accounts they are responsible for.

11. The Health Center should include clinical incentive payments in institutional base salary.

Comment:

The Health Center excludes certain types of incentive payments from institutional base salary. Some are inconsequential; the two most significant are research incentives (related to the amount of salary a researcher manages to charge to external awards) and clinical incentives (related to collections on patient billings) payments. Though it seems clear that research incentive payments are being handled correctly, i.e., they should be excluded, it appears reasonable to include clinical incentive payments in institutional base salary.

12. The Health Center should improve control over compensatory time by addressing the accumulation of large balances.

Comment:

We noted that some Health Center employees had accumulated large compensatory time balances. Further, the number of employees with large accumulations appears to be increasing. In previous reviews, we found that 15 employees had balances of 400 hours or more as of March 27, 2002, and 31 employees had balances of 400 hours or more as of June 17, 2005. As of July 5, 2007, 38 employees had balances of 400 hours or more. One employee had accumulated more than 961 hours.

13. The Health Center should require all employees that accumulate compensated absences to submit biweekly attendance reports to the Payroll Department.

Comment:

Though the Health Center has historically accounted for faculty members' compensated absences in this manner, we could not readily ascertain why. Though management responded negatively to our prior recommendation addressing this control deficiency, the response did not cite any obstacles to converting or benefits accruing from the current system.

INDEPENDENT AUDITORS' CERTIFICATION

As required by Section 2-90 of the General Statutes we have audited the books and accounts of the University of Connecticut Health Center (Health Center) for the fiscal years ended June 30, 2005 and 2006. This audit was primarily limited to performing tests of the Health Center's compliance with certain provisions of laws, regulations, contracts and grants, and to understanding and evaluating the effectiveness of the Health Center's internal control policies and procedures for ensuring that (1) the provisions of certain laws, regulations, contracts and grants applicable to the Health Center are complied with, (2) the financial transactions of the Health Center are properly recorded, processed, summarized and reported on consistent with management's authorization, and (3) the assets of the Health Center are safeguarded against loss or unauthorized use. The financial statement audits of the Health Center for the fiscal years ended June 30, 2005 and 2006, are reported upon separately and are included as a part of our Statewide Single Audit of the State of Connecticut for those fiscal years.

We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the Health Center complied in all material or significant respects with the provisions of certain laws, regulations, contracts and grants and to obtain a sufficient understanding of the internal control to plan the audit and determine the nature, timing and extent of tests to be performed during the conduct of the audit.

Compliance:

Compliance with the requirements of laws, regulations, contracts and grants applicable to the Health Center is the responsibility of the Health Center's management.

As part of obtaining reasonable assurance about whether the Health Center complied with laws, regulations, contracts and grants, noncompliance with which could result in significant unauthorized, illegal, irregular or unsafe transactions or could have a direct and material effect on the results of the Health Center's financial operations for the fiscal years ended June 30, 2005 and 2006, we performed tests of its compliance with certain provisions of the laws, regulations, contracts and grants. However, an opinion on compliance with these provisions was not an objective of our audit, and accordingly, we do not express such an opinion.

The results of our tests disclosed no instances of noncompliance that are required to be reported under *Government Auditing Standards*.

Internal Control over Financial Operations, Safeguarding of Assets and Compliance:

The management of the Health Center is responsible for establishing and maintaining effective internal control over its financial operations, safeguarding of assets, and compliance with the requirements of laws, regulations, contracts and grants applicable to the Health Center. In planning and performing our audit, we considered the Health Center's internal control over its financial operations, safeguarding of assets, and compliance with requirements that could have a material or significant effect on the Health Center's financial operations in order to determine

our auditing procedures for the purpose of evaluating the Health Center's financial operations, safeguarding of assets, and compliance with certain provisions of laws, regulations, contracts and grants, and not to provide assurance on the internal control over those control objectives.

However, we noted certain matters involving the internal control over the Health Center's financial operations, safeguarding of assets, and/or compliance that we consider to be reportable conditions. Reportable conditions involve matters coming to our attention relating to significant deficiencies in the design or operation of internal control over the Health Center's financial operations, safeguarding of assets, and/or compliance that, in our judgment, could adversely affect the Health Center's ability to properly record, process, summarize and report financial data consistent with management's authorization, safeguard assets, and/or comply with certain provisions of laws, regulations, contracts, and grants. We believe the following findings represent reportable conditions: authorizing contractors to begin work before execution of contracts and a decentralized recordkeeping system for faculty compensated absences.

A material or significant weakness is a condition in which the design or operation of one or more of the internal control components does not reduce to a relatively low level the risk that noncompliance with certain provisions of laws, regulations, contracts, and grants or the requirements to safeguard assets that would be material in relation to the Health Center's financial operations or noncompliance which could result in significant unauthorized, illegal, irregular or unsafe transactions to the Health Center may occur and not be detected within a timely period by employees in the normal course of performing their assigned functions. Our consideration of the internal control over the Health Center's financial operations and over compliance would not necessarily disclose all matters in the internal control that might be reportable conditions, and accordingly, would not necessarily disclose all reportable conditions that are also considered to be a material or significant weaknesses. However, of the reportable conditions described above, we believe the following reportable condition to be a material or significant weakness: authorizing contractors to begin work before execution of contracts.

This report is intended for the information of the Governor, the State Comptroller, the Appropriations Committee of the General Assembly and the Legislative Committee on Program Review and Investigations. However, this report is a matter of public record and its distribution is not limited.

CONCLUSION

We wish to express our appreciation to the staff of the Health Center for the cooperation and courtesies extended to our representatives during this examination.



James K. Carroll
Principal Auditor

Approved:

Kevin P. Johnston
Auditor of Public Accounts

Robert G. Jaekle
Auditor of Public Accounts